1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10649

10666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 77 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: EDW. W. McCREANY MEMO. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 CRISFIELD
d. STREET ADDRESS: 1 MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: HUBBARD — Last: DAUGHERTY

4. DATE OF DEATH: Month: SEPTEMBER — Day: 19 — Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-3-1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Investments

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles O. Daugherty

14. MOTHER'S MAIDEN NAME: Maggie Dize

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: MARY M. DAUGHERTY, Address: CRISFIELD, MD.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 mins
DUE TO (b): Angina pectoris — years
DUE TO (c): Coronary arteriosclerosis — yrs

420.1

Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to SEPT. 19, 1959, that I last saw the deceased alive on SEPT. 19, 1959, and that death occurred at 10:35PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: C P Rawley M.D. — ADDRESS (Street, city or town, state): CRISFIELD, MARYLAND — DATE SIGNED: 9/20/59

PHYSICIAN'S NAME (Type): C. G. RAWLEY, M.D., — CRISFIELD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept.22,1959

22c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery

22d. LOCATION (City, town, or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bradshaw & Sons--Crisfield, Md.

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,7 FilmG249 10-6-59 et

CERTIFICATE OF DEATH

10667 Reg. Dist. No. 10650

1. PLACE OF DEATH
a. COUNTY Somerset MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First (Algie) Algie Middle (Buoy) Buoy Last Ford
4. DATE OF DEATH Month Sept Day 24 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Apr 8, 1874
9. AGE (If years last birthday) 85 yrs.
IF UNDER 1 YEAR Months 9 Days 24
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm H. Ford
14. MOTHER'S MAIDEN NAME Mary A. Maryland Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Calvert Ford Balto,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema	2 days
DUE TO	442X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertensive Cardio-Vascular	3 yrs
DUE TO (c)	Renal Disease	5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar, 1955 to Sept 26, 1959, that I last saw the deceased alive on Sept 25, 1959, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE B. Frank Gigante M.D. ADDRESS (Street, city or town, state) Princess Anne Md DATE SIGNED 9/26/59

PHYSICIAN'S NAME (Type) B. FRANK GIGANTI

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept 27, 1959
22c. NAME OF CEMETERY OR CREMATORY Kok Upper Fairmount
22d. LOCATION (City, town, or county) (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Harry B. Miles ADDRESS Upper Fairmount Md
24a. RECD BY REGISTRAR DATE SEP 29 59
24b. REGISTRAR'S SIGNATURE Cullins & Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10668

CERTIFICATE OF DEATH

10651

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: E.W. McCREADY MEMO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARION STATION
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DEBORAH — Middle ANNE — Last HOLDEN

4. DATE OF DEATH: Month SEPT — Day 7TH — Year 1959

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 7, 1959

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 1 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CRISFIELD, MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ISAAC HOLDEN

14. MOTHER'S MAIDEN NAME: ROSALEE WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

INFORMANT: ISAAC HOLDEN — Address: MARION STATION, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Debility Acute Dil. of Heart — INTERVAL BETWEEN ONSET AND DEATH: 6 days

756.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pylora Spasm

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mal Nutrition — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1 AM, 1959 to SEPT 7TH, 1959, that I last saw the deceased alive on SEPT 7TH, 1959, and that death occurred at 4 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George C Coulbourn M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 9/8/59

PHYSICIAN'S NAME (Type): GEORGE C. COULBOURN, M.D, MARION STATION, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT 10-59

22c. NAME OF CEMETERY OR CREMATORY: FAMILY

22d. LOCATION (City, town, or county) (State): MARION STATION, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Charles H Ward — ADDRESS: Marion md.

24a. REC'D BY REGISTRAR DATE: SEP 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10669

Reg. Dist. No. 10652

1. PLACE OF DEATH
a. COUNTY Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter
d. STREET ADDRESS Main Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ruth Middle E. Last Jones

4. DATE OF DEATH Month Sept. Day 24 Year 1959

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 4-1894
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Duties
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Matthew Roxbury
14. MOTHER'S MAIDEN NAME Charlotte Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-16-7787
17. INFORMANT Luther Jones Address Dames Quarter Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: sudden

443X

DUE TO (b) Congestive failure — 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertensive cardiovascular disease — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 2, 1959 to Sept 24, 1959 that I last saw the deceased alive on Sept 24, 19___, and that death occurred at 2a M, from the causes and on the date stated above.

ACTUAL SIGNATURE Everett C Sutter M.D. ADDRESS (Street, city or town, state) Dames Quarter, Maryland DATE SIGNED 9-25-59

PHYSICIAN'S NAME (Type) Everett C. Sutter M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-27-59
22c. NAME OF CEMETERY OR CREMATORY Macedonia Methodist
22d. LOCATION (City, town, or county) (State) Dames Quarter Md.

23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster ADDRESS Deal Island Md
24a. REC'D BY REGISTRAR DATE OCT 1 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10670 Reg. Dist. No. 10653

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pocomoke City
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. 1

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Pocomoke City
d. STREET ADDRESS: R.F.D. 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ANNIE — Middle L. — Last LONG

4. DATE OF DEATH: Month September — Day 24 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 18, 1887

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Powell

14. MOTHER'S MAIDEN NAME: Harriett W. Dryden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Maurice S. Long, RFD 1, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 2 days
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Degenerative Heart Disease — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Nephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 8, 1950 to Sept. 24, 1959, that I last saw the deceased alive on Sept. 24, 1959, and that death occurred at 1:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles W Trader M.D. — ADDRESS (Street, city or town, state): 302 Market St., Pocomoke City, Md. — DATE SIGNED: 9/26/59

PHYSICIAN'S NAME (Type): Charles W. Trader, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-27-59

22c. NAME OF CEMETERY: Rehobeth Presbyterian

22d. LOCATION (City, town, or county) (State): Rehobeth, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10671

CERTIFICATE OF DEATH

11821

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pocomoke
c. LENGTH OF STAY IN 1b: Life Long
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pocomoke City
d. STREET ADDRESS: R 2 D #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Wilbs — Last: Long

4. DATE OF DEATH: Month: 9 — Day: 29 — Year: 1959

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15 1879

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher

10b. KIND OF BUSINESS OR INDUSTRY: Meat Packing

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Handy Long

14. MOTHER'S MAIDEN NAME: Mary Pilot

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-4125

17. INFORMANT: Mrs Wilbs Long — Address: Pocomoke Md RR 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Lung ?
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c): Probably Cigarette Smoking - Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 9th 19 59, to Sept 29th 19 59, that I last saw the deceased alive on Sept 26th 19 59, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Sartorius M.D.
ADDRESS (Street, city or town, state): Pocomoke City, Md
DATE SIGNED: 9/30/59
PHYSICIAN'S NAME (Type): N. E Sartorius.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-4-59
22c. NAME OF CEMETERY OR CREMATORY: Findley Chapel
22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton
ADDRESS: New Church, Va.

24a. REC'D BY REGISTRAR DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10654

10672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Somerset MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Somerset
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town) Princess Anne
d. STREET ADDRESS 1253 Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Laura Middle Catherine Last Maddox

4. DATE OF DEATH Month Sept Day 9 Year 1959

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 24, 1885
9. AGE (In years lost birthday) 73 yrs. IF UNDER 1 YEAR Months 9 Days 17 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) work for C&P Tele
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Rockawalkin Wicomico Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME IVIRNG PARSONS
14. MOTHER'S MAIDEN NAME SARAH THOMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-20-4236
INFORMANT Walter Maddox Address 253 Church St. Pr. A.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonia	5 days
DUE TO (b)	Cardiac Decompensation	1 yr.
DUE TO (c)	Renal Disease	2 yrs

593 X

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot I ottended the deceosed from Mar, 1958, to Sept 9, 1959, that I lost sow the deceosed alive on Sept 9, 1959, ond thot deoth occurred at 9:00 M, from the causes ond on the dote stated obave.

ACTUAL SIGNATURE B. Frank Gigante M.D. ADDRESS (Street, city or town, stote) Princess Anne DATE SIGNED 9/11/59

PHYSICIAN'S NAME (Type) B. FRANK GIGANTI

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 13, 1959
22c. NAME OF CEMETERY OR CREMATORY Metropolitan
22d. LOCATION (City, town, or county) (Stote) Princess Anne, Som. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward ADDRESS Marion Sta., Md. #235
24a. REC'D BY REGISTRAR DATE SEP 17 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10673

CERTIFICATE OF DEATH

Reg. Dist. No. 10655

1. PLACE OF DEATH
o. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: E.W.McCREADY MEMO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RUMBLEY
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LENA — Middle M. — Lost MEREDITH
4. DATE OF DEATH: Month SEPT — Day 7 — Year 19 59

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: MAY 18, 1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN FRENCH
14. MOTHER'S MAIDEN NAME: ESTHER BLAKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
INFORMANT: DULANEY MEREDITH — Address: RUMBLEY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Dil of Heart — INTERVAL BETWEEN ONSET AND DEATH
260X
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying cause lost.
DUE TO (b): Diabetis Mellitus
DUE TO (c): Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): General Artero Sclerosis Cerebral Atrophy Rheumatic — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to SEPT 7, 1959, that I last saw the deceased alive on SEPT 7TH, 1959, and that death occurred at 5:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George C Coulbourn M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 9/8/59

PHYSICIAN'S NAME (Type): GEORGE C COULBOURN, M.D. — MARION STATION, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 10, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mechanics Cemetery
22d. LOCATION (City, town, or county) (State): Fairmount, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bradshaw & Sons, Crisfield, Md.
24a. REC'D BY REGISTRAR DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10674

CERTIFICATE OF DEATH

Reg. Dist. No. 10656

1. PLACE OF DEATH
o. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: EDW. W. McCREADY MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × KINGSTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROBERT — Middle — Last WHITTINGTON

4. DATE OF DEATH: Month SEPTEMBER — Day 15 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 18-1879

9. AGE (In years lost birthday): 86 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JEFF WHITTINGTON

14. MOTHER'S MAIDEN NAME: LOUISE Fields.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-12-1818

INFORMANT: BERNICE WHITTINGTON, KINGSTON, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Dilat Heart — INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs

442×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic Hypertension Arteriosclerosis — Yrs

DUE TO (c): General Arteriosclerosis — Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 1959, to Sept 15, 1959, that I last saw the deceased alive on Sept 14, 1959, and that death occurred at 6:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George C Coulbourn M.D. — ADDRESS (Street, city or town, state): MARION, MARYLAND — DATE SIGNED: 9/15/59

PHYSICIAN'S NAME (Type): GEORGE C. COULBOURN, M.D. MARION, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Sept 17-59

22c. NAME OF CEMETERY OR CREMATORY: WATERS CHAPEL

22d. LOCATION (City, town, or county) (State): MARION SOM, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Charles H Ward — ADDRESS: marion md

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Carlton B. Kinsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675 Reg. Dist. No. 10657

1. PLACE OF DEATH
a. COUNTY Somerset MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station
c. LENGTH OF STAY IN 1b
(NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. Geo. Widdowson's Mc Creedy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station
d. STREET ADDRESS Main Station Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Broudas Middle Lost Williams
4. DATE OF DEATH Month Sept. Day 26 Year 1959
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec. 20, 1941
9. AGE (Years last birthday) 17 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Marion Station
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Williams
14. MOTHER'S MAIDEN NAME Bertha Beauchamp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-38-[illegible] 9635
17. INFORMANT Thomas Williams Address Marion Sta., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto Mobile Accident
823X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fractured Skull-Lacerated
DUE TO (c) Left Forehead
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Shock
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

William H. Coulbourn
DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A auto accident
20c. TIME OF INJURY Hour a. m. p.m. Month, Day, Year 9-26-1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Kingston
20f. (City or town) Kingston (County) Somerset (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Noturol causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Wm H. Coulbourn M.D.
EXAMINER'S NAME (Type) Wm H. Coulbourn M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 29 '59
22c. NAME OF CEMETERY ~~OR CREMATORY~~ Branch
22d. LOCATION (City, town, or county) Marion Sta, Som. Co. (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward ADDRESS Marion Sta., Md.
24a. REC'D BY REGISTRAR DATE OCT 6 '59
24b. REGISTRAR'S SIGNATURE Catherine L. Kinnard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10658 Reg. Dist. No.

10665

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 12 Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Crisfield
d. STREET ADDRESS: 1 12 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EMMA — Middle CULLEN — Last WYATT

4. DATE OF DEATH: Month September — Day 21 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1866

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Crisfield, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Cullen

14. MOTHER'S MAIDEN NAME: Melissa Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Pearl Muir, 12 Main St., Crisfield, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b): Arteriosclerosis — years
DUE TO
(c):

332 X

Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 29, 19 59, to Sept. 21, 19 59 that I last saw the deceased alive an Sept. 21, 19 59, and that death accurred at 3:30 P.M. fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Sarah M. Peyton M.D.
ADDRESS (Street, city or town, state): 33 W. Main St.
DATE SIGNED: 9/24/59

PHYSICIAN'S NAME (Type): Sarah M. Peyton, M. D. — Crisfield, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery
22d. LOCATION (City, town, or county) (State): Crisfield, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bradshaw & Sons, Crisfield, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Cathryn L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58